

SB3336



101ST GENERAL ASSEMBLY

State of Illinois

2019 and 2020

SB3336

Introduced 2/14/2020, by Sen. Heather A. Steans

SYNOPSIS AS INTRODUCED:

305 ILCS 5/5-5
305 ILCS 5/5-5f

from Ch. 23, par. 5-5

Amends the Medical Assistance Article of the Illinois Public Aid Code. Expands the list of covered services under the medical assistance program to include services performed by a chiropractic physician licensed under the Medical Practice Act of 1987 and acting within the scope of his or her license, including, but not limited to, chiropractic manipulative treatment. Removes a provision that eliminates adult chiropractic services as a covered service under the medical assistance program.

LRB101 19592 KTG 69068 b

FISCAL NOTE ACT
MAY APPLY

A BILL FOR

1 AN ACT concerning public aid.

2 **Be it enacted by the People of the State of Illinois,**
3 **represented in the General Assembly:**

4 Section 5. The Illinois Public Aid Code is amended by
5 changing Sections 5-5 and 5-5f as follows:

6 (305 ILCS 5/5-5) (from Ch. 23, par. 5-5)

7 Sec. 5-5. Medical services. The Illinois Department, by
8 rule, shall determine the quantity and quality of and the rate
9 of reimbursement for the medical assistance for which payment
10 will be authorized, and the medical services to be provided,
11 which may include all or part of the following: (1) inpatient
12 hospital services; (2) outpatient hospital services; (3) other
13 laboratory and X-ray services; (4) skilled nursing home
14 services; (5) physicians' services whether furnished in the
15 office, the patient's home, a hospital, a skilled nursing home,
16 or elsewhere; (6) medical care, or any other type of remedial
17 care furnished by licensed practitioners; (7) home health care
18 services; (8) private duty nursing service; (9) clinic
19 services; (10) dental services, including prevention and
20 treatment of periodontal disease and dental caries disease for
21 pregnant women, provided by an individual licensed to practice
22 dentistry or dental surgery; for purposes of this item (10),
23 "dental services" means diagnostic, preventive, or corrective

1 procedures provided by or under the supervision of a dentist in
2 the practice of his or her profession; (11) physical therapy
3 and related services; (12) prescribed drugs, dentures, and
4 prosthetic devices; and eyeglasses prescribed by a physician
5 skilled in the diseases of the eye, or by an optometrist,
6 whichever the person may select; (13) other diagnostic,
7 screening, preventive, and rehabilitative services, including
8 to ensure that the individual's need for intervention or
9 treatment of mental disorders or substance use disorders or
10 co-occurring mental health and substance use disorders is
11 determined using a uniform screening, assessment, and
12 evaluation process inclusive of criteria, for children and
13 adults; for purposes of this item (13), a uniform screening,
14 assessment, and evaluation process refers to a process that
15 includes an appropriate evaluation and, as warranted, a
16 referral; "uniform" does not mean the use of a singular
17 instrument, tool, or process that all must utilize; (14)
18 transportation and such other expenses as may be necessary;
19 (15) medical treatment of sexual assault survivors, as defined
20 in Section 1a of the Sexual Assault Survivors Emergency
21 Treatment Act, for injuries sustained as a result of the sexual
22 assault, including examinations and laboratory tests to
23 discover evidence which may be used in criminal proceedings
24 arising from the sexual assault; (16) the diagnosis and
25 treatment of sickle cell anemia; (16.5) services performed by a
26 chiropractic physician licensed under the Medical Practice Act

1 of 1987 and acting within the scope of his or her license,
2 including, but not limited to, chiropractic manipulative
3 treatment; and (17) any other medical care, and any other type
4 of remedial care recognized under the laws of this State. The
5 term "any other type of remedial care" shall include nursing
6 care and nursing home service for persons who rely on treatment
7 by spiritual means alone through prayer for healing.

8 Notwithstanding any other provision of this Section, a
9 comprehensive tobacco use cessation program that includes
10 purchasing prescription drugs or prescription medical devices
11 approved by the Food and Drug Administration shall be covered
12 under the medical assistance program under this Article for
13 persons who are otherwise eligible for assistance under this
14 Article.

15 Notwithstanding any other provision of this Code,
16 reproductive health care that is otherwise legal in Illinois
17 shall be covered under the medical assistance program for
18 persons who are otherwise eligible for medical assistance under
19 this Article.

20 Notwithstanding any other provision of this Code, the
21 Illinois Department may not require, as a condition of payment
22 for any laboratory test authorized under this Article, that a
23 physician's handwritten signature appear on the laboratory
24 test order form. The Illinois Department may, however, impose
25 other appropriate requirements regarding laboratory test order
26 documentation.

1 Upon receipt of federal approval of an amendment to the
2 Illinois Title XIX State Plan for this purpose, the Department
3 shall authorize the Chicago Public Schools (CPS) to procure a
4 vendor or vendors to manufacture eyeglasses for individuals
5 enrolled in a school within the CPS system. CPS shall ensure
6 that its vendor or vendors are enrolled as providers in the
7 medical assistance program and in any capitated Medicaid
8 managed care entity (MCE) serving individuals enrolled in a
9 school within the CPS system. Under any contract procured under
10 this provision, the vendor or vendors must serve only
11 individuals enrolled in a school within the CPS system. Claims
12 for services provided by CPS's vendor or vendors to recipients
13 of benefits in the medical assistance program under this Code,
14 the Children's Health Insurance Program, or the Covering ALL
15 KIDS Health Insurance Program shall be submitted to the
16 Department or the MCE in which the individual is enrolled for
17 payment and shall be reimbursed at the Department's or the
18 MCE's established rates or rate methodologies for eyeglasses.

19 On and after July 1, 2012, the Department of Healthcare and
20 Family Services may provide the following services to persons
21 eligible for assistance under this Article who are
22 participating in education, training or employment programs
23 operated by the Department of Human Services as successor to
24 the Department of Public Aid:

- 25 (1) dental services provided by or under the
26 supervision of a dentist; and

1 (2) eyeglasses prescribed by a physician skilled in the
2 diseases of the eye, or by an optometrist, whichever the
3 person may select.

4 On and after July 1, 2018, the Department of Healthcare and
5 Family Services shall provide dental services to any adult who
6 is otherwise eligible for assistance under the medical
7 assistance program. As used in this paragraph, "dental
8 services" means diagnostic, preventative, restorative, or
9 corrective procedures, including procedures and services for
10 the prevention and treatment of periodontal disease and dental
11 caries disease, provided by an individual who is licensed to
12 practice dentistry or dental surgery or who is under the
13 supervision of a dentist in the practice of his or her
14 profession.

15 On and after July 1, 2018, targeted dental services, as set
16 forth in Exhibit D of the Consent Decree entered by the United
17 States District Court for the Northern District of Illinois,
18 Eastern Division, in the matter of Memisovski v. Maram, Case
19 No. 92 C 1982, that are provided to adults under the medical
20 assistance program shall be established at no less than the
21 rates set forth in the "New Rate" column in Exhibit D of the
22 Consent Decree for targeted dental services that are provided
23 to persons under the age of 18 under the medical assistance
24 program.

25 Notwithstanding any other provision of this Code and
26 subject to federal approval, the Department may adopt rules to

1 allow a dentist who is volunteering his or her service at no
2 cost to render dental services through an enrolled
3 not-for-profit health clinic without the dentist personally
4 enrolling as a participating provider in the medical assistance
5 program. A not-for-profit health clinic shall include a public
6 health clinic or Federally Qualified Health Center or other
7 enrolled provider, as determined by the Department, through
8 which dental services covered under this Section are performed.
9 The Department shall establish a process for payment of claims
10 for reimbursement for covered dental services rendered under
11 this provision.

12 The Illinois Department, by rule, may distinguish and
13 classify the medical services to be provided only in accordance
14 with the classes of persons designated in Section 5-2.

15 The Department of Healthcare and Family Services must
16 provide coverage and reimbursement for amino acid-based
17 elemental formulas, regardless of delivery method, for the
18 diagnosis and treatment of (i) eosinophilic disorders and (ii)
19 short bowel syndrome when the prescribing physician has issued
20 a written order stating that the amino acid-based elemental
21 formula is medically necessary.

22 The Illinois Department shall authorize the provision of,
23 and shall authorize payment for, screening by low-dose
24 mammography for the presence of occult breast cancer for women
25 35 years of age or older who are eligible for medical
26 assistance under this Article, as follows:

1 (A) A baseline mammogram for women 35 to 39 years of
2 age.

3 (B) An annual mammogram for women 40 years of age or
4 older.

5 (C) A mammogram at the age and intervals considered
6 medically necessary by the woman's health care provider for
7 women under 40 years of age and having a family history of
8 breast cancer, prior personal history of breast cancer,
9 positive genetic testing, or other risk factors.

10 (D) A comprehensive ultrasound screening and MRI of an
11 entire breast or breasts if a mammogram demonstrates
12 heterogeneous or dense breast tissue or when medically
13 necessary as determined by a physician licensed to practice
14 medicine in all of its branches.

15 (E) A screening MRI when medically necessary, as
16 determined by a physician licensed to practice medicine in
17 all of its branches.

18 (F) A diagnostic mammogram when medically necessary,
19 as determined by a physician licensed to practice medicine
20 in all its branches, advanced practice registered nurse, or
21 physician assistant.

22 The Department shall not impose a deductible, coinsurance,
23 copayment, or any other cost-sharing requirement on the
24 coverage provided under this paragraph; except that this
25 sentence does not apply to coverage of diagnostic mammograms to
26 the extent such coverage would disqualify a high-deductible

1 health plan from eligibility for a health savings account
2 pursuant to Section 223 of the Internal Revenue Code (26 U.S.C.
3 223).

4 All screenings shall include a physical breast exam,
5 instruction on self-examination and information regarding the
6 frequency of self-examination and its value as a preventative
7 tool.

8 For purposes of this Section:

9 "Diagnostic mammogram" means a mammogram obtained using
10 diagnostic mammography.

11 "Diagnostic mammography" means a method of screening that
12 is designed to evaluate an abnormality in a breast, including
13 an abnormality seen or suspected on a screening mammogram or a
14 subjective or objective abnormality otherwise detected in the
15 breast.

16 "Low-dose mammography" means the x-ray examination of the
17 breast using equipment dedicated specifically for mammography,
18 including the x-ray tube, filter, compression device, and image
19 receptor, with an average radiation exposure delivery of less
20 than one rad per breast for 2 views of an average size breast.
21 The term also includes digital mammography and includes breast
22 tomosynthesis.

23 "Breast tomosynthesis" means a radiologic procedure that
24 involves the acquisition of projection images over the
25 stationary breast to produce cross-sectional digital
26 three-dimensional images of the breast.

1 If, at any time, the Secretary of the United States
2 Department of Health and Human Services, or its successor
3 agency, promulgates rules or regulations to be published in the
4 Federal Register or publishes a comment in the Federal Register
5 or issues an opinion, guidance, or other action that would
6 require the State, pursuant to any provision of the Patient
7 Protection and Affordable Care Act (Public Law 111-148),
8 including, but not limited to, 42 U.S.C. 18031(d)(3)(B) or any
9 successor provision, to defray the cost of any coverage for
10 breast tomosynthesis outlined in this paragraph, then the
11 requirement that an insurer cover breast tomosynthesis is
12 inoperative other than any such coverage authorized under
13 Section 1902 of the Social Security Act, 42 U.S.C. 1396a, and
14 the State shall not assume any obligation for the cost of
15 coverage for breast tomosynthesis set forth in this paragraph.

16 On and after January 1, 2016, the Department shall ensure
17 that all networks of care for adult clients of the Department
18 include access to at least one breast imaging Center of Imaging
19 Excellence as certified by the American College of Radiology.

20 On and after January 1, 2012, providers participating in a
21 quality improvement program approved by the Department shall be
22 reimbursed for screening and diagnostic mammography at the same
23 rate as the Medicare program's rates, including the increased
24 reimbursement for digital mammography.

25 The Department shall convene an expert panel including
26 representatives of hospitals, free-standing mammography

1 facilities, and doctors, including radiologists, to establish
2 quality standards for mammography.

3 On and after January 1, 2017, providers participating in a
4 breast cancer treatment quality improvement program approved
5 by the Department shall be reimbursed for breast cancer
6 treatment at a rate that is no lower than 95% of the Medicare
7 program's rates for the data elements included in the breast
8 cancer treatment quality program.

9 The Department shall convene an expert panel, including
10 representatives of hospitals, free-standing breast cancer
11 treatment centers, breast cancer quality organizations, and
12 doctors, including breast surgeons, reconstructive breast
13 surgeons, oncologists, and primary care providers to establish
14 quality standards for breast cancer treatment.

15 Subject to federal approval, the Department shall
16 establish a rate methodology for mammography at federally
17 qualified health centers and other encounter-rate clinics.
18 These clinics or centers may also collaborate with other
19 hospital-based mammography facilities. By January 1, 2016, the
20 Department shall report to the General Assembly on the status
21 of the provision set forth in this paragraph.

22 The Department shall establish a methodology to remind
23 women who are age-appropriate for screening mammography, but
24 who have not received a mammogram within the previous 18
25 months, of the importance and benefit of screening mammography.
26 The Department shall work with experts in breast cancer

1 outreach and patient navigation to optimize these reminders and
2 shall establish a methodology for evaluating their
3 effectiveness and modifying the methodology based on the
4 evaluation.

5 The Department shall establish a performance goal for
6 primary care providers with respect to their female patients
7 over age 40 receiving an annual mammogram. This performance
8 goal shall be used to provide additional reimbursement in the
9 form of a quality performance bonus to primary care providers
10 who meet that goal.

11 The Department shall devise a means of case-managing or
12 patient navigation for beneficiaries diagnosed with breast
13 cancer. This program shall initially operate as a pilot program
14 in areas of the State with the highest incidence of mortality
15 related to breast cancer. At least one pilot program site shall
16 be in the metropolitan Chicago area and at least one site shall
17 be outside the metropolitan Chicago area. On or after July 1,
18 2016, the pilot program shall be expanded to include one site
19 in western Illinois, one site in southern Illinois, one site in
20 central Illinois, and 4 sites within metropolitan Chicago. An
21 evaluation of the pilot program shall be carried out measuring
22 health outcomes and cost of care for those served by the pilot
23 program compared to similarly situated patients who are not
24 served by the pilot program.

25 The Department shall require all networks of care to
26 develop a means either internally or by contract with experts

1 in navigation and community outreach to navigate cancer
2 patients to comprehensive care in a timely fashion. The
3 Department shall require all networks of care to include access
4 for patients diagnosed with cancer to at least one academic
5 commission on cancer-accredited cancer program as an
6 in-network covered benefit.

7 Any medical or health care provider shall immediately
8 recommend, to any pregnant woman who is being provided prenatal
9 services and is suspected of having a substance use disorder as
10 defined in the Substance Use Disorder Act, referral to a local
11 substance use disorder treatment program licensed by the
12 Department of Human Services or to a licensed hospital which
13 provides substance abuse treatment services. The Department of
14 Healthcare and Family Services shall assure coverage for the
15 cost of treatment of the drug abuse or addiction for pregnant
16 recipients in accordance with the Illinois Medicaid Program in
17 conjunction with the Department of Human Services.

18 All medical providers providing medical assistance to
19 pregnant women under this Code shall receive information from
20 the Department on the availability of services under any
21 program providing case management services for addicted women,
22 including information on appropriate referrals for other
23 social services that may be needed by addicted women in
24 addition to treatment for addiction.

25 The Illinois Department, in cooperation with the
26 Departments of Human Services (as successor to the Department

1 of Alcoholism and Substance Abuse) and Public Health, through a
2 public awareness campaign, may provide information concerning
3 treatment for alcoholism and drug abuse and addiction, prenatal
4 health care, and other pertinent programs directed at reducing
5 the number of drug-affected infants born to recipients of
6 medical assistance.

7 Neither the Department of Healthcare and Family Services
8 nor the Department of Human Services shall sanction the
9 recipient solely on the basis of her substance abuse.

10 The Illinois Department shall establish such regulations
11 governing the dispensing of health services under this Article
12 as it shall deem appropriate. The Department should seek the
13 advice of formal professional advisory committees appointed by
14 the Director of the Illinois Department for the purpose of
15 providing regular advice on policy and administrative matters,
16 information dissemination and educational activities for
17 medical and health care providers, and consistency in
18 procedures to the Illinois Department.

19 The Illinois Department may develop and contract with
20 Partnerships of medical providers to arrange medical services
21 for persons eligible under Section 5-2 of this Code.
22 Implementation of this Section may be by demonstration projects
23 in certain geographic areas. The Partnership shall be
24 represented by a sponsor organization. The Department, by rule,
25 shall develop qualifications for sponsors of Partnerships.
26 Nothing in this Section shall be construed to require that the

1 sponsor organization be a medical organization.

2 The sponsor must negotiate formal written contracts with
3 medical providers for physician services, inpatient and
4 outpatient hospital care, home health services, treatment for
5 alcoholism and substance abuse, and other services determined
6 necessary by the Illinois Department by rule for delivery by
7 Partnerships. Physician services must include prenatal and
8 obstetrical care. The Illinois Department shall reimburse
9 medical services delivered by Partnership providers to clients
10 in target areas according to provisions of this Article and the
11 Illinois Health Finance Reform Act, except that:

12 (1) Physicians participating in a Partnership and
13 providing certain services, which shall be determined by
14 the Illinois Department, to persons in areas covered by the
15 Partnership may receive an additional surcharge for such
16 services.

17 (2) The Department may elect to consider and negotiate
18 financial incentives to encourage the development of
19 Partnerships and the efficient delivery of medical care.

20 (3) Persons receiving medical services through
21 Partnerships may receive medical and case management
22 services above the level usually offered through the
23 medical assistance program.

24 Medical providers shall be required to meet certain
25 qualifications to participate in Partnerships to ensure the
26 delivery of high quality medical services. These

1 qualifications shall be determined by rule of the Illinois
2 Department and may be higher than qualifications for
3 participation in the medical assistance program. Partnership
4 sponsors may prescribe reasonable additional qualifications
5 for participation by medical providers, only with the prior
6 written approval of the Illinois Department.

7 Nothing in this Section shall limit the free choice of
8 practitioners, hospitals, and other providers of medical
9 services by clients. In order to ensure patient freedom of
10 choice, the Illinois Department shall immediately promulgate
11 all rules and take all other necessary actions so that provided
12 services may be accessed from therapeutically certified
13 optometrists to the full extent of the Illinois Optometric
14 Practice Act of 1987 without discriminating between service
15 providers.

16 The Department shall apply for a waiver from the United
17 States Health Care Financing Administration to allow for the
18 implementation of Partnerships under this Section.

19 The Illinois Department shall require health care
20 providers to maintain records that document the medical care
21 and services provided to recipients of Medical Assistance under
22 this Article. Such records must be retained for a period of not
23 less than 6 years from the date of service or as provided by
24 applicable State law, whichever period is longer, except that
25 if an audit is initiated within the required retention period
26 then the records must be retained until the audit is completed

1 and every exception is resolved. The Illinois Department shall
2 require health care providers to make available, when
3 authorized by the patient, in writing, the medical records in a
4 timely fashion to other health care providers who are treating
5 or serving persons eligible for Medical Assistance under this
6 Article. All dispensers of medical services shall be required
7 to maintain and retain business and professional records
8 sufficient to fully and accurately document the nature, scope,
9 details and receipt of the health care provided to persons
10 eligible for medical assistance under this Code, in accordance
11 with regulations promulgated by the Illinois Department. The
12 rules and regulations shall require that proof of the receipt
13 of prescription drugs, dentures, prosthetic devices and
14 eyeglasses by eligible persons under this Section accompany
15 each claim for reimbursement submitted by the dispenser of such
16 medical services. No such claims for reimbursement shall be
17 approved for payment by the Illinois Department without such
18 proof of receipt, unless the Illinois Department shall have put
19 into effect and shall be operating a system of post-payment
20 audit and review which shall, on a sampling basis, be deemed
21 adequate by the Illinois Department to assure that such drugs,
22 dentures, prosthetic devices and eyeglasses for which payment
23 is being made are actually being received by eligible
24 recipients. Within 90 days after September 16, 1984 (the
25 effective date of Public Act 83-1439), the Illinois Department
26 shall establish a current list of acquisition costs for all

1 prosthetic devices and any other items recognized as medical
2 equipment and supplies reimbursable under this Article and
3 shall update such list on a quarterly basis, except that the
4 acquisition costs of all prescription drugs shall be updated no
5 less frequently than every 30 days as required by Section
6 5-5.12.

7 Notwithstanding any other law to the contrary, the Illinois
8 Department shall, within 365 days after July 22, 2013 (the
9 effective date of Public Act 98-104), establish procedures to
10 permit skilled care facilities licensed under the Nursing Home
11 Care Act to submit monthly billing claims for reimbursement
12 purposes. Following development of these procedures, the
13 Department shall, by July 1, 2016, test the viability of the
14 new system and implement any necessary operational or
15 structural changes to its information technology platforms in
16 order to allow for the direct acceptance and payment of nursing
17 home claims.

18 Notwithstanding any other law to the contrary, the Illinois
19 Department shall, within 365 days after August 15, 2014 (the
20 effective date of Public Act 98-963), establish procedures to
21 permit ID/DD facilities licensed under the ID/DD Community Care
22 Act and MC/DD facilities licensed under the MC/DD Act to submit
23 monthly billing claims for reimbursement purposes. Following
24 development of these procedures, the Department shall have an
25 additional 365 days to test the viability of the new system and
26 to ensure that any necessary operational or structural changes

1 to its information technology platforms are implemented.

2 The Illinois Department shall require all dispensers of
3 medical services, other than an individual practitioner or
4 group of practitioners, desiring to participate in the Medical
5 Assistance program established under this Article to disclose
6 all financial, beneficial, ownership, equity, surety or other
7 interests in any and all firms, corporations, partnerships,
8 associations, business enterprises, joint ventures, agencies,
9 institutions or other legal entities providing any form of
10 health care services in this State under this Article.

11 The Illinois Department may require that all dispensers of
12 medical services desiring to participate in the medical
13 assistance program established under this Article disclose,
14 under such terms and conditions as the Illinois Department may
15 by rule establish, all inquiries from clients and attorneys
16 regarding medical bills paid by the Illinois Department, which
17 inquiries could indicate potential existence of claims or liens
18 for the Illinois Department.

19 Enrollment of a vendor shall be subject to a provisional
20 period and shall be conditional for one year. During the period
21 of conditional enrollment, the Department may terminate the
22 vendor's eligibility to participate in, or may disenroll the
23 vendor from, the medical assistance program without cause.
24 Unless otherwise specified, such termination of eligibility or
25 disenrollment is not subject to the Department's hearing
26 process. However, a disenrolled vendor may reapply without

1 penalty.

2 The Department has the discretion to limit the conditional
3 enrollment period for vendors based upon category of risk of
4 the vendor.

5 Prior to enrollment and during the conditional enrollment
6 period in the medical assistance program, all vendors shall be
7 subject to enhanced oversight, screening, and review based on
8 the risk of fraud, waste, and abuse that is posed by the
9 category of risk of the vendor. The Illinois Department shall
10 establish the procedures for oversight, screening, and review,
11 which may include, but need not be limited to: criminal and
12 financial background checks; fingerprinting; license,
13 certification, and authorization verifications; unscheduled or
14 unannounced site visits; database checks; prepayment audit
15 reviews; audits; payment caps; payment suspensions; and other
16 screening as required by federal or State law.

17 The Department shall define or specify the following: (i)
18 by provider notice, the "category of risk of the vendor" for
19 each type of vendor, which shall take into account the level of
20 screening applicable to a particular category of vendor under
21 federal law and regulations; (ii) by rule or provider notice,
22 the maximum length of the conditional enrollment period for
23 each category of risk of the vendor; and (iii) by rule, the
24 hearing rights, if any, afforded to a vendor in each category
25 of risk of the vendor that is terminated or disenrolled during
26 the conditional enrollment period.

1 To be eligible for payment consideration, a vendor's
2 payment claim or bill, either as an initial claim or as a
3 resubmitted claim following prior rejection, must be received
4 by the Illinois Department, or its fiscal intermediary, no
5 later than 180 days after the latest date on the claim on which
6 medical goods or services were provided, with the following
7 exceptions:

8 (1) In the case of a provider whose enrollment is in
9 process by the Illinois Department, the 180-day period
10 shall not begin until the date on the written notice from
11 the Illinois Department that the provider enrollment is
12 complete.

13 (2) In the case of errors attributable to the Illinois
14 Department or any of its claims processing intermediaries
15 which result in an inability to receive, process, or
16 adjudicate a claim, the 180-day period shall not begin
17 until the provider has been notified of the error.

18 (3) In the case of a provider for whom the Illinois
19 Department initiates the monthly billing process.

20 (4) In the case of a provider operated by a unit of
21 local government with a population exceeding 3,000,000
22 when local government funds finance federal participation
23 for claims payments.

24 For claims for services rendered during a period for which
25 a recipient received retroactive eligibility, claims must be
26 filed within 180 days after the Department determines the

1 applicant is eligible. For claims for which the Illinois
2 Department is not the primary payer, claims must be submitted
3 to the Illinois Department within 180 days after the final
4 adjudication by the primary payer.

5 In the case of long term care facilities, within 45
6 calendar days of receipt by the facility of required
7 prescreening information, new admissions with associated
8 admission documents shall be submitted through the Medical
9 Electronic Data Interchange (MEDI) or the Recipient
10 Eligibility Verification (REV) System or shall be submitted
11 directly to the Department of Human Services using required
12 admission forms. Effective September 1, 2014, admission
13 documents, including all prescreening information, must be
14 submitted through MEDI or REV. Confirmation numbers assigned to
15 an accepted transaction shall be retained by a facility to
16 verify timely submittal. Once an admission transaction has been
17 completed, all resubmitted claims following prior rejection
18 are subject to receipt no later than 180 days after the
19 admission transaction has been completed.

20 Claims that are not submitted and received in compliance
21 with the foregoing requirements shall not be eligible for
22 payment under the medical assistance program, and the State
23 shall have no liability for payment of those claims.

24 To the extent consistent with applicable information and
25 privacy, security, and disclosure laws, State and federal
26 agencies and departments shall provide the Illinois Department

1 access to confidential and other information and data necessary
2 to perform eligibility and payment verifications and other
3 Illinois Department functions. This includes, but is not
4 limited to: information pertaining to licensure;
5 certification; earnings; immigration status; citizenship; wage
6 reporting; unearned and earned income; pension income;
7 employment; supplemental security income; social security
8 numbers; National Provider Identifier (NPI) numbers; the
9 National Practitioner Data Bank (NPDB); program and agency
10 exclusions; taxpayer identification numbers; tax delinquency;
11 corporate information; and death records.

12 The Illinois Department shall enter into agreements with
13 State agencies and departments, and is authorized to enter into
14 agreements with federal agencies and departments, under which
15 such agencies and departments shall share data necessary for
16 medical assistance program integrity functions and oversight.
17 The Illinois Department shall develop, in cooperation with
18 other State departments and agencies, and in compliance with
19 applicable federal laws and regulations, appropriate and
20 effective methods to share such data. At a minimum, and to the
21 extent necessary to provide data sharing, the Illinois
22 Department shall enter into agreements with State agencies and
23 departments, and is authorized to enter into agreements with
24 federal agencies and departments, including, but not limited
25 to: the Secretary of State; the Department of Revenue; the
26 Department of Public Health; the Department of Human Services;

1 and the Department of Financial and Professional Regulation.

2 Beginning in fiscal year 2013, the Illinois Department
3 shall set forth a request for information to identify the
4 benefits of a pre-payment, post-adjudication, and post-edit
5 claims system with the goals of streamlining claims processing
6 and provider reimbursement, reducing the number of pending or
7 rejected claims, and helping to ensure a more transparent
8 adjudication process through the utilization of: (i) provider
9 data verification and provider screening technology; and (ii)
10 clinical code editing; and (iii) pre-pay, pre- or
11 post-adjudicated predictive modeling with an integrated case
12 management system with link analysis. Such a request for
13 information shall not be considered as a request for proposal
14 or as an obligation on the part of the Illinois Department to
15 take any action or acquire any products or services.

16 The Illinois Department shall establish policies,
17 procedures, standards and criteria by rule for the acquisition,
18 repair and replacement of orthotic and prosthetic devices and
19 durable medical equipment. Such rules shall provide, but not be
20 limited to, the following services: (1) immediate repair or
21 replacement of such devices by recipients; and (2) rental,
22 lease, purchase or lease-purchase of durable medical equipment
23 in a cost-effective manner, taking into consideration the
24 recipient's medical prognosis, the extent of the recipient's
25 needs, and the requirements and costs for maintaining such
26 equipment. Subject to prior approval, such rules shall enable a

1 recipient to temporarily acquire and use alternative or
2 substitute devices or equipment pending repairs or
3 replacements of any device or equipment previously authorized
4 for such recipient by the Department. Notwithstanding any
5 provision of Section 5-5f to the contrary, the Department may,
6 by rule, exempt certain replacement wheelchair parts from prior
7 approval and, for wheelchairs, wheelchair parts, wheelchair
8 accessories, and related seating and positioning items,
9 determine the wholesale price by methods other than actual
10 acquisition costs.

11 The Department shall require, by rule, all providers of
12 durable medical equipment to be accredited by an accreditation
13 organization approved by the federal Centers for Medicare and
14 Medicaid Services and recognized by the Department in order to
15 bill the Department for providing durable medical equipment to
16 recipients. No later than 15 months after the effective date of
17 the rule adopted pursuant to this paragraph, all providers must
18 meet the accreditation requirement.

19 In order to promote environmental responsibility, meet the
20 needs of recipients and enrollees, and achieve significant cost
21 savings, the Department, or a managed care organization under
22 contract with the Department, may provide recipients or managed
23 care enrollees who have a prescription or Certificate of
24 Medical Necessity access to refurbished durable medical
25 equipment under this Section (excluding prosthetic and
26 orthotic devices as defined in the Orthotics, Prosthetics, and

1 Pedorthics Practice Act and complex rehabilitation technology
2 products and associated services) through the State's
3 assistive technology program's reutilization program, using
4 staff with the Assistive Technology Professional (ATP)
5 Certification if the refurbished durable medical equipment:
6 (i) is available; (ii) is less expensive, including shipping
7 costs, than new durable medical equipment of the same type;
8 (iii) is able to withstand at least 3 years of use; (iv) is
9 cleaned, disinfected, sterilized, and safe in accordance with
10 federal Food and Drug Administration regulations and guidance
11 governing the reprocessing of medical devices in health care
12 settings; and (v) equally meets the needs of the recipient or
13 enrollee. The reutilization program shall confirm that the
14 recipient or enrollee is not already in receipt of same or
15 similar equipment from another service provider, and that the
16 refurbished durable medical equipment equally meets the needs
17 of the recipient or enrollee. Nothing in this paragraph shall
18 be construed to limit recipient or enrollee choice to obtain
19 new durable medical equipment or place any additional prior
20 authorization conditions on enrollees of managed care
21 organizations.

22 The Department shall execute, relative to the nursing home
23 prescreening project, written inter-agency agreements with the
24 Department of Human Services and the Department on Aging, to
25 effect the following: (i) intake procedures and common
26 eligibility criteria for those persons who are receiving

1 non-institutional services; and (ii) the establishment and
2 development of non-institutional services in areas of the State
3 where they are not currently available or are undeveloped; and
4 (iii) notwithstanding any other provision of law, subject to
5 federal approval, on and after July 1, 2012, an increase in the
6 determination of need (DON) scores from 29 to 37 for applicants
7 for institutional and home and community-based long term care;
8 if and only if federal approval is not granted, the Department
9 may, in conjunction with other affected agencies, implement
10 utilization controls or changes in benefit packages to
11 effectuate a similar savings amount for this population; and
12 (iv) no later than July 1, 2013, minimum level of care
13 eligibility criteria for institutional and home and
14 community-based long term care; and (v) no later than October
15 1, 2013, establish procedures to permit long term care
16 providers access to eligibility scores for individuals with an
17 admission date who are seeking or receiving services from the
18 long term care provider. In order to select the minimum level
19 of care eligibility criteria, the Governor shall establish a
20 workgroup that includes affected agency representatives and
21 stakeholders representing the institutional and home and
22 community-based long term care interests. This Section shall
23 not restrict the Department from implementing lower level of
24 care eligibility criteria for community-based services in
25 circumstances where federal approval has been granted.

26 The Illinois Department shall develop and operate, in

1 cooperation with other State Departments and agencies and in
2 compliance with applicable federal laws and regulations,
3 appropriate and effective systems of health care evaluation and
4 programs for monitoring of utilization of health care services
5 and facilities, as it affects persons eligible for medical
6 assistance under this Code.

7 The Illinois Department shall report annually to the
8 General Assembly, no later than the second Friday in April of
9 1979 and each year thereafter, in regard to:

10 (a) actual statistics and trends in utilization of
11 medical services by public aid recipients;

12 (b) actual statistics and trends in the provision of
13 the various medical services by medical vendors;

14 (c) current rate structures and proposed changes in
15 those rate structures for the various medical vendors; and

16 (d) efforts at utilization review and control by the
17 Illinois Department.

18 The period covered by each report shall be the 3 years
19 ending on the June 30 prior to the report. The report shall
20 include suggested legislation for consideration by the General
21 Assembly. The requirement for reporting to the General Assembly
22 shall be satisfied by filing copies of the report as required
23 by Section 3.1 of the General Assembly Organization Act, and
24 filing such additional copies with the State Government Report
25 Distribution Center for the General Assembly as is required
26 under paragraph (t) of Section 7 of the State Library Act.

1 Rulemaking authority to implement Public Act 95-1045, if
2 any, is conditioned on the rules being adopted in accordance
3 with all provisions of the Illinois Administrative Procedure
4 Act and all rules and procedures of the Joint Committee on
5 Administrative Rules; any purported rule not so adopted, for
6 whatever reason, is unauthorized.

7 On and after July 1, 2012, the Department shall reduce any
8 rate of reimbursement for services or other payments or alter
9 any methodologies authorized by this Code to reduce any rate of
10 reimbursement for services or other payments in accordance with
11 Section 5-5e.

12 Because kidney transplantation can be an appropriate,
13 cost-effective alternative to renal dialysis when medically
14 necessary and notwithstanding the provisions of Section 1-11 of
15 this Code, beginning October 1, 2014, the Department shall
16 cover kidney transplantation for noncitizens with end-stage
17 renal disease who are not eligible for comprehensive medical
18 benefits, who meet the residency requirements of Section 5-3 of
19 this Code, and who would otherwise meet the financial
20 requirements of the appropriate class of eligible persons under
21 Section 5-2 of this Code. To qualify for coverage of kidney
22 transplantation, such person must be receiving emergency renal
23 dialysis services covered by the Department. Providers under
24 this Section shall be prior approved and certified by the
25 Department to perform kidney transplantation and the services
26 under this Section shall be limited to services associated with

1 kidney transplantation.

2 Notwithstanding any other provision of this Code to the
3 contrary, on or after July 1, 2015, all FDA approved forms of
4 medication assisted treatment prescribed for the treatment of
5 alcohol dependence or treatment of opioid dependence shall be
6 covered under both fee for service and managed care medical
7 assistance programs for persons who are otherwise eligible for
8 medical assistance under this Article and shall not be subject
9 to any (1) utilization control, other than those established
10 under the American Society of Addiction Medicine patient
11 placement criteria, (2) prior authorization mandate, or (3)
12 lifetime restriction limit mandate.

13 On or after July 1, 2015, opioid antagonists prescribed for
14 the treatment of an opioid overdose, including the medication
15 product, administration devices, and any pharmacy fees related
16 to the dispensing and administration of the opioid antagonist,
17 shall be covered under the medical assistance program for
18 persons who are otherwise eligible for medical assistance under
19 this Article. As used in this Section, "opioid antagonist"
20 means a drug that binds to opioid receptors and blocks or
21 inhibits the effect of opioids acting on those receptors,
22 including, but not limited to, naloxone hydrochloride or any
23 other similarly acting drug approved by the U.S. Food and Drug
24 Administration.

25 Upon federal approval, the Department shall provide
26 coverage and reimbursement for all drugs that are approved for

1 marketing by the federal Food and Drug Administration and that
2 are recommended by the federal Public Health Service or the
3 United States Centers for Disease Control and Prevention for
4 pre-exposure prophylaxis and related pre-exposure prophylaxis
5 services, including, but not limited to, HIV and sexually
6 transmitted infection screening, treatment for sexually
7 transmitted infections, medical monitoring, assorted labs, and
8 counseling to reduce the likelihood of HIV infection among
9 individuals who are not infected with HIV but who are at high
10 risk of HIV infection.

11 A federally qualified health center, as defined in Section
12 1905(1)(2)(B) of the federal Social Security Act, shall be
13 reimbursed by the Department in accordance with the federally
14 qualified health center's encounter rate for services provided
15 to medical assistance recipients that are performed by a dental
16 hygienist, as defined under the Illinois Dental Practice Act,
17 working under the general supervision of a dentist and employed
18 by a federally qualified health center.

19 (Source: P.A. 100-201, eff. 8-18-17; 100-395, eff. 1-1-18;
20 100-449, eff. 1-1-18; 100-538, eff. 1-1-18; 100-587, eff.
21 6-4-18; 100-759, eff. 1-1-19; 100-863, eff. 8-14-18; 100-974,
22 eff. 8-19-18; 100-1009, eff. 1-1-19; 100-1018, eff. 1-1-19;
23 100-1148, eff. 12-10-18; 101-209, eff. 8-5-19; 101-580, eff.
24 1-1-20; revised 9-18-19.)

25 (305 ILCS 5/5-5f)

1 Sec. 5-5f. Elimination and limitations of medical
2 assistance services. Notwithstanding any other provision of
3 this Code to the contrary, on and after July 1, 2012:

4 (a) The following service ~~services~~ shall no longer be a
5 covered service available under this Code: group
6 psychotherapy for residents of any facility licensed under
7 the Nursing Home Care Act or the Specialized Mental Health
8 Rehabilitation Act of 2013, ~~and adult chiropractic~~
9 ~~services~~.

10 (b) The Department shall place the following
11 limitations on services: (i) the Department shall limit
12 adult eyeglasses to one pair every 2 years; however, the
13 limitation does not apply to an individual who needs
14 different eyeglasses following a surgical procedure such
15 as cataract surgery; (ii) the Department shall set an
16 annual limit of a maximum of 20 visits for each of the
17 following services: adult speech, hearing, and language
18 therapy services, adult occupational therapy services, and
19 physical therapy services; on or after October 1, 2014, the
20 annual maximum limit of 20 visits shall expire but the
21 Department may require prior approval for all individuals
22 for speech, hearing, and language therapy services,
23 occupational therapy services, and physical therapy
24 services; (iii) the Department shall limit adult podiatry
25 services to individuals with diabetes; on or after October
26 1, 2014, podiatry services shall not be limited to

1 individuals with diabetes; (iv) the Department shall pay
2 for caesarean sections at the normal vaginal delivery rate
3 unless a caesarean section was medically necessary; (v) the
4 Department shall limit adult dental services to
5 emergencies; beginning July 1, 2013, the Department shall
6 ensure that the following conditions are recognized as
7 emergencies: (A) dental services necessary for an
8 individual in order for the individual to be cleared for a
9 medical procedure, such as a transplant; (B) extractions
10 and dentures necessary for a diabetic to receive proper
11 nutrition; (C) extractions and dentures necessary as a
12 result of cancer treatment; and (D) dental services
13 necessary for the health of a pregnant woman prior to
14 delivery of her baby; on or after July 1, 2014, adult
15 dental services shall no longer be limited to emergencies,
16 and dental services necessary for the health of a pregnant
17 woman prior to delivery of her baby shall continue to be
18 covered; and (vi) effective July 1, 2012, the Department
19 shall place limitations and require concurrent review on
20 every inpatient detoxification stay to prevent repeat
21 admissions to any hospital for detoxification within 60
22 days of a previous inpatient detoxification stay. The
23 Department shall convene a workgroup of hospitals,
24 substance abuse providers, care coordination entities,
25 managed care plans, and other stakeholders to develop
26 recommendations for quality standards, diversion to other

1 settings, and admission criteria for patients who need
2 inpatient detoxification, which shall be published on the
3 Department's website no later than September 1, 2013.

4 (c) The Department shall require prior approval of the
5 following services: wheelchair repairs costing more than
6 \$400, coronary artery bypass graft, and bariatric surgery
7 consistent with Medicare standards concerning patient
8 responsibility. Wheelchair repair prior approval requests
9 shall be adjudicated within one business day of receipt of
10 complete supporting documentation. Providers may not break
11 wheelchair repairs into separate claims for purposes of
12 staying under the \$400 threshold for requiring prior
13 approval. The wholesale price of manual and power
14 wheelchairs, durable medical equipment and supplies, and
15 complex rehabilitation technology products and services
16 shall be defined as actual acquisition cost including all
17 discounts.

18 (d) The Department shall establish benchmarks for
19 hospitals to measure and align payments to reduce
20 potentially preventable hospital readmissions, inpatient
21 complications, and unnecessary emergency room visits. In
22 doing so, the Department shall consider items, including,
23 but not limited to, historic and current acuity of care and
24 historic and current trends in readmission. The Department
25 shall publish provider-specific historical readmission
26 data and anticipated potentially preventable targets 60

1 days prior to the start of the program. In the instance of
2 readmissions, the Department shall adopt policies and
3 rates of reimbursement for services and other payments
4 provided under this Code to ensure that, by June 30, 2013,
5 expenditures to hospitals are reduced by, at a minimum,
6 \$40,000,000.

7 (e) The Department shall establish utilization
8 controls for the hospice program such that it shall not pay
9 for other care services when an individual is in hospice.

10 (f) For home health services, the Department shall
11 require Medicare certification of providers participating
12 in the program and implement the Medicare face-to-face
13 encounter rule. The Department shall require providers to
14 implement auditable electronic service verification based
15 on global positioning systems or other cost-effective
16 technology.

17 (g) For the Home Services Program operated by the
18 Department of Human Services and the Community Care Program
19 operated by the Department on Aging, the Department of
20 Human Services, in cooperation with the Department on
21 Aging, shall implement an electronic service verification
22 based on global positioning systems or other
23 cost-effective technology.

24 (h) Effective with inpatient hospital admissions on or
25 after July 1, 2012, the Department shall reduce the payment
26 for a claim that indicates the occurrence of a

1 provider-preventable condition during the admission as
2 specified by the Department in rules. The Department shall
3 not pay for services related to an other
4 provider-preventable condition.

5 As used in this subsection (h):

6 "Provider-preventable condition" means a health care
7 acquired condition as defined under the federal Medicaid
8 regulation found at 42 CFR 447.26 or an other
9 provider-preventable condition.

10 "Other provider-preventable condition" means a wrong
11 surgical or other invasive procedure performed on a
12 patient, a surgical or other invasive procedure performed
13 on the wrong body part, or a surgical procedure or other
14 invasive procedure performed on the wrong patient.

15 (i) The Department shall implement cost savings
16 initiatives for advanced imaging services, cardiac imaging
17 services, pain management services, and back surgery. Such
18 initiatives shall be designed to achieve annual costs
19 savings.

20 (j) The Department shall ensure that beneficiaries
21 with a diagnosis of epilepsy or seizure disorder in
22 Department records will not require prior approval for
23 anticonvulsants.

24 (Source: P.A. 100-135, eff. 8-18-17; 101-209, eff. 8-5-19.)